NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Central Bedfordshire

Central Bedfordshire Integration and Better Care Fund Plan 2025/26

Contents

Introduction

The Central Bedfordshire Integration and Better Care Fund Plan (BCF) 2025/26 outlines the commitment to delivering integrated, person-centered health and social care services. This plan aligns with national priorities and local strategies, including the place plan, Bedfordshire Care Alliance (BCA), the Integrated Care System's Strategy, the Integrated Care Board's Joint Forward Plan and the BLMK Operational Plan.

As Central Bedfordshire's population grows and ages with the highest percentage increase expected in people aged 85 years and over, the demand for health and social care services continues to rise.

Central Bedfordshire faces challenges in managing multiple long-term conditions, supporting independent living, and shifting care from hospitals to community-based settings. The BCF Plan responds to these challenges by promoting preventative care, timely interventions, and integrated service delivery.

Key priorities include:

- Shifting focus from sickness to prevention, with an emphasis on community-based health initiatives.
- Enhancing independent living, ensuring seamless hospital-to-home transitions.
- Reducing reliance on institutional care, through investment in reablement and home support services.
- Strengthening partnerships, working closely with voluntary organisations, housing services, and local communities.

The plan builds upon ongoing efforts to integrate primary care, mental health, and social care services, aiming for better coordination and improved outcomes for residents. Investment in digital health solutions, workforce development, and community-based support networks is central to achieving these goals.

This is particularly important for us, in view of the current local financial challenges and our geography. With much of our population living in our rural towns and villages, it is important to see that real shift from reliance on acute hospitals and other institutionalised forms of care to a more community-based focus. Achieving this requires local health and care organisations to work together to design new care models with an important emphasis on prevention and independent living. The development of the Integrated Neighbourhood Working (INW) programme will create opportunities to work with residents and our local communities, particularly voluntary sector organisations to promote an asset-based approach and build on the very critical networks of support and capacity close to where people live.

The BLMK Health Services Strategy 2024-2040 outlines a comprehensive plan to enhance health services across BLMK, focusing on integration, innovation, and improved health outcomes for residents. There are plans to develop the BLMK Mental Health, Learning Disability and Autism (MHLDA) Collaborative that aims to improve approaches to support individuals with MHLDA, ensuring access to appropriate care and support. There is an ambition to develop Bedfordshire's Gold Virtual Ward that focuses on end of life and can be accessed both step up from community and step down from hospital and aims to reduce admission and re-admission into acute settings.

The ICB Board signed off the BLMK Operational Plan on 26th March 2025. In summary:

a) The BLMK Plan is a balanced financial plan for 2025/26; and,

b) Our plan is compliant with nearly all national targets/expectations, but not all (Children & Young People (CYP) Mental Health access).

BLMK ICB is developing a strategic plan aimed at increasing CYP access by strengthening voluntary sector support for early years provision. Areas where our targets are not compliant, we have "still put forward an ambitious plan demonstrating improvement from current performance".

Governance and oversight are maintained through collaboration between Central Bedfordshire Council, the Integrated Care Board (ICB), and the Health and Wellbeing Board, ensuring that the plan delivers effective and sustainable healthcare solutions for residents.

This BCF Plan for 2025/26 sets a clear direction for better care, closer to home, fostering healthier communities and a more sustainable health and social care system.

Objective 1: reform to support the shift from sickness to prevention

Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

Objective 2: reform to support people living independently and the shift from hospital to home

Local areas must agree plans that:

- help prevent avoidable hospital admissions.
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care.

It sets out our approach to meet the national requirements for Health and Care systems to produce a short, jointly agreed narrative plan that describes how the national conditions and performance metrics are being addressed.

This BCF Plan has met all the national conditions and was developed through our continuing partnership and reflects partnership priorities for the BCF. It takes account of the requirements for the use of the Local Authority Better Care Grant and the Disabled Facilities Grant (DFG).

Principally, the priorities set out in the Plan reflect the local partnership priorities of our Health and Wellbeing Board (HWB) and Bedfordshire Luton and Milton Keynes (BLMK) Integrated Care Board (ICB). All these key stakeholders are part of the governance described later in this plan.

Executive Summary

Central Bedfordshire is an area of significant economic opportunity with planned housing and employment growth and is a desirable place to live. It is the 11th largest Unitary Council area in the country, predominantly rural in character and one of the least densely populated. While this dispersed, rural identity is what makes Central Bedfordshire an attractive place to live, it also poses challenges for getting around and accessing shops, services and jobs close to home.

The population of Central Bedfordshire grew 16% in the ten years between 2011 and 2021, and the ethnic diversity increased from a low base. This is very high growth compared to the 6.3% average for England and Wales over the same period. In the twenty years between 2023 and 2043 it is forecast to grow 31% and although ethnic diversity will continue to increase, it will remain less diverse than England and considerably less diverse than the rest of the ICB areas.

In 2023, the four most common recorded health conditions were: hypertension (16.4% of the population), anxiety (16.3%), depression (11.8%) and musculoskeletal conditions (11.4%). The rising number of older adults in the population means that by 2043 the prevalence of hypertension is forecast to increase to 19.0%, followed by anxiety (16.3%), MSK (13.4%) and then depression (11.7%). While cardiovascular disease, cancer and chronic kidney disease are less common, they will show notable increases in prevalence over this time.

While the population is forecast to grow by 31%, if people carry on making use of healthcare at the same age- and sex-specific rates as today, by 2043 Central Bedfordshire's population will generate:

- 39% (around 500,000) more primary care consultations per year
- 40% (around 170,000) additional outpatient attendances per year
- 34% (around 30,000) more visits to A&E per year
- 42% (around 18,000) more elective (planned) admissions per year
- 44% (around 11,500) more emergency admissions per year

While overall population growth is contributing to this increase, the ageing population is also an important factor. The majority of people driving this increase are already resident in our population with approximately 56,000 people aged 65 and over and this is expected to increase by 41% in 2035. The population aged 85 and over is forecast to increase at a faster rate, by 79%, between 2023-2035. In the longer term, the ageing population, specifically those aged 85 and over, is predicted to double in the next 20 years. Population ageing means that the use of healthcare in the future will increase more than the population overall. Types of healthcare activity that are most commonly used by older people will see the greatest rise. Only A&E attendances will rise more in line with the overall population increase.

Activity increases on this scale will be a significant challenge for a social and healthcare system that is already over-stretched. This reinforces the need for transformation, both to take a more preventative approach to building a healthier population and to make the healthcare system more efficient. Even if both of these are achieved, however, it is difficult to see how they could mitigate activity increases of this scale, without also requiring investment in additional healthcare staffing capacity and infrastructure (Director of Public Health Annual Report, Feb-25).

Furthermore, our adult social care provider market, as in other places, is under pressure and sustainability, particularly remains a concern. Addressing the significant workforce capacity issues across all providers of health and social care both in terms of carers remains a key priority.

Governance

Our BCF plan is developed in partnership between Central Bedfordshire Council and the Integrated Care Board (ICB) and is jointly agreed. Delivery of the plan and overall integration approach is overseen by the Health and Wellbeing Board (HWB), which includes the executive members for Health, Adult Social Care and Children's Services, alongside the chief officers from the ICB and Central Bedfordshire Council. The membership of the HWB board also includes the statutory Directors of Social Care, Public Health, Place and Communities, Children's Services, along with representatives of the Primary Care Networks, health provider trusts and the voluntary sector.

Central Bedfordshire Council is a unitary authority and holds responsibility for housing and disbursement of the DFG through the Director for Adult Social Care, and Housing.

Our Central Bedfordshire Joint Leadership Group (formally Place Board) is the Place Based partnership that brings together senior leaders and partners to provide a collective view of system issues for Central Bedfordshire as a 'Place' and making best use of the total resources available to the partners to meet the specific needs of Central Bedfordshire residents. It brings together all key partners from across health and social care to coordinate the delivery of targeted local solutions that achieve the priorities and ambitions of the Health and Wellbeing Board. Fundamental to our Joint Leadership Group is focussing on the whole population, irrespective of age.

The Joint Leadership Group ensures alignment of strategic plans and vision across the ICS and at Place to deliver integrated outcomes for Central Bedfordshire residents. Importantly, the Group advances a population health management approach to understand and predict future health and care needs with Primary Care Networks as essential building blocks. It oversees a collaborative approach to addressing local challenges and appropriate use of system-wide flexibilities, including collaborative commissioning, where appropriate to deliver solutions that maximise outcomes for residents.

Key areas of focus for the Joint Leadership Group are:

- Alignment of strategic plans and place vision across primary care, community, mental health and social care to deliver integrated outcomes. Advance ambitions around joint working; joint commissioning and shared resources – at 'place'.
- Delivery of Place Plan.
- Estates – Maximise public assets for the local population.
- Sustainability of the social care market.
- Better Care Fund Plan – use of integrated/pooled funds.
- Oversight of Bedfordshire Care Alliance workstreams.

- Community Health Services Transformation.
- Deliver improvements on key service challenges and access e.g. SEND; Primary Care; Waiting Lists.
- Update on implementation of Primary Care strategy - at 'place'.
- Mental Health Transformation – operational delivery and outcomes.
- Building on the digital shift towards 'digital by default' agenda. Implications for digital inclusion.
- Workforce – attracting and retaining our workforce – oversight and working alongside the People Board.
- Review Place Based Population Health data to ensure that performance improvements are in line with Central Bedfordshire's statistical family groups.
- Co-production at place.

Due to the cohesive nature of the Central Bedfordshire and the BLMK strategic and operational plans, including the BCF Plan, no allocation will operate in isolation. A Joint BCF Group has been set up to oversee 2025-2026 decisions ensure there is an interconnectivity which generates a greater picture and collectively drives improved outcomes for our residents. Partners agree that Central Bedfordshire BCF Plan must remain agile within its strategic direction, to ensure we are able to respond to local and national influences impacting on our citizens. As such, the BCF allocation will be subject to quarterly reviews against performance and outcomes. The reviews will operate on a value for money traffic light system, providing performance oversight to the group members and facilitating a "continue-improve-stop" decision, ensuring that we strengthen our investment and outputs and provide opportunities to adapt to the changing needs of residents.

Priorities for 2025/26

The BCF schemes and priorities for 2025/26 in Central Bedfordshire aim to enhance outcomes for residents, promote efficient service delivery, and support independent living.

There are targeted initiatives that help people to remain independent in their own homes; facilitated joint working and integration of intermediate care and reablement services; achieving closer working across the system to reduce delay to transfer of care from hospitals. These priorities reflect the ambitions in our Joint Health and Wellbeing Strategy and Place Plan that are aligned to the place priorities and areas of focus.

Central Bedfordshire Joint Health and Wellbeing Strategy 2024-2029 long-term vision - *To improve the health and wellbeing of residents in Central Bedfordshire and reduce inequalities now and for future generations.* The areas of focus include:

- Giving children in Central Bedfordshire the best start in life with a focus on educational attainment
- Tackling social isolation and loneliness across all sectors of society
- Making Central Bedfordshire a smoke-free place
- Securing improved and integrated health and care outcomes through delivery of our Place Plan

This sits alongside our existing Place Plan priorities for Central Bedfordshire:

- Reducing excess weight in children and adults
- Earlier diagnosis of cancer
- Positive mental health for children and young people
- Improving mental health services and support for people with learning disabilities and autism
- Improving access to primary care and dentistry
- Improving out of hospital services

The Joint Health and Wellbeing Strategy sets out how we intend to support people living independently and includes:

- Enhancing care in the community for older people, helping residents stay independent and reducing hospital admissions.
- Expanding support for carers and social networks to provide better home care alternatives.
- Using technology and digital tools to help residents manage their own health more effectively, reducing the need for medical intervention.

The Joint Health and Wellbeing Strategy sets out how we intend to support the prevention and early intervention agenda by:

- Increasing screening and early diagnosis for conditions like cancer to improve outcomes and reduce the need for hospital treatment.
- Promoting self-care and healthier lifestyles, such as smoking cessation and weight management programs, to prevent long-term health conditions.
- Implementing social prescribing and better use of community resources to address social isolation and mental health, reducing reliance on acute healthcare services.
- Improving access to primary care and dentistry to reduce pressure on hospitals.
- Enhancing out-of-hospital services to ensure timely discharge and prevent unnecessary hospital stays.
- Providing same-day urgent care to prevent hospital admissions for conditions that can be managed in the community.
- Expanding community-based mental health services to support those with complex needs outside of hospital settings.
- Strengthening personalised care closer to where people live, ensuring better local access to support.

These challenges, desired outcomes and enablers for each of the six areas above are set out in the Place Plan Delivery framework for 2025/26.

Primary Care (PC) Access including dentistry

The residents of Central Bedfordshire have expressed:

- Challenges in accessing primary care services
- Not able to make contact with practices on the telephone
- Report that there are excessive waits in accessing appointments

Challenges

- Demand for Primary Care in general practice is high
- Inconsistent understanding of the full Primary Care offer and how general practice works
- Full range of professionals in general practice are not widely known & understood
- Some residents expect to be seen face to face, and by a GP
- From 1st April 2023, ICB has delegated responsibility for Community Pharmacy, Optometry & Dental services

Outcomes desired

- Integrated neighbourhood teams delivery
- MiDOSis fully available
- Full Primary Care Offer Defined
- Residents supported to manage their health & wellbeing
- Qualifying residents timely access NHS Dental & Optometry services
- Public Health & Prevention: Community Pharmacy, Optometry & Dental service contracts are maximised with improvements to population health outcomes

Current situation

- **More** appointments now than before the pandemic
- % of face to face is **higher** than national average
- Place based bulletins launched
- **Direct communication** with PPGs & Healthwatch
- PCNs developing **Access Improvement Plans**
- **Bespoke support** to practices with most significant access challenge
- **Plan for delivery** of integrated PC in development with all CBC stakeholders
- **Working Together** in Leighton Buzzard developing & being scoped for implementation
- BLMK ICB **delegated commissioning** of Pharmacy, Optometry and Dentistry
- **Lowest prevalence** of tooth decay in 5year-olds in BLMK, lower than regional & national average
- Lowest level of extraction & the highest level of care index

Enabling Change

- Clear and transparent communication with the residents and stakeholders
- Digitally enabled care is embedded and utilised
- Supported to understand how to navigate across PC and other offers to support self care
- Workforce- the whole PC and general practice workforce is understood by residen
- Telephony needs to be improved in practic in Central Bedfordshire
- A PHM approach to providing proactive an personalised primary care- there will be continuing focus on addressing health inequalities

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Cancer diagnosis and improving outcomes

Challenges

- Late stage diagnoses
- Deaths from cancer within 5 years of diagnosis
- Cancers which are preventable
- Deprivation difference in mortality rates for most cancers in men and women deprived non-white ethnicity
- Too few people are able to take up the cancer screening programmes
- Emergency presentations higher than the national average
- Rates of premature mortality (<75 yrs) are higher than the deprivation decile average, particularly for males (2020 data)
- Falling into the cracks between primary & secondary care
- More people with SMI die prematurely than without.

Outcomes desired

- 75% **diagnosed at an early stage**
- **>60% uptake of bowel cancer screening in each deprivation decile**
- **>80% % uptake of breast cancer screening in each deprivation decile**
- **>80 % uptake of cervical cancer screening in each deprivation decile**
- Uptake for cervical screening (25-49 yr olds) & bowel screening **Reduced the gap in premature mortality with** and without **SMI**
- **Reduced smoking prevalence.**
- **Fewer people living with excess weight**
- Increased offered or accepted Personalised Care & Support Plan
- **Improved patient experience** of the of the whole cancer pathway

Current situation

Prevention

- Extension **lung health check programme**
- Morelife & NHS digital weight loss programme capacity
- **Stop smoking support** - virtually and face to face
- Support people to be **physically active**
- **Active Lifestyle Referral** – referral from GP & other health professionals
- Development of walking and cycling infrastructure

Treatment and early identification

- Launched **non-specific cancer symptoms pathway**
- Communications **cancer signs & symptoms** & screening
- Proposals to increase **access to radiotherapy**
- **Active Lifestyle Referral** Prehab
- **Primary Care education programme** to improve primary care early identification & patient support
- Introduction of **genomics testing** to support decision making for breast cancer patients

Enabling Change

Prevention

- PHM **data** to stratify groups at higher risk
- Increase access to **stop smoking (with SMI)**
- Ambitions within the **Director of Public Health Report 2022**
- Increase **physically active**
- **Promoting healthy lifestyles**

Treatment and early identification

- Better **personalised integrated patient journeys**
- **Access to screening programmes** outside of normal working hours & locations targeted populations
- Understanding **barriers to cancer screening programmes**
- Increased understanding of **cancer signs, symptoms, referral pathways** incl. **community connectors**
- **Improved access to quality care & support closer to home**
- More emphasis on **case finding programmes**
- Piloting **new & less invasive diagnostic technologies for gastric cancers**
- Further focus on **diagnostics and genetic testing**

Central Bedfordshire Better care locally

Positive Mental Health and Well Being for Children and Young People

1.

Challenges

- Improve children & young people's emotional & mental health and wellbeing
- Services are integral in education
- Supporting celebration of who they are: build confidence, resilience & providing a sense of belonging.
- Five pathways across the THRIVE framework.
- Sufficient services and resources that empower children and young people.
- Up-to-date, easily accessible information for children, young people and their families
- Children with complex needs through timely multi-agency collaboration and effective targeted and specialist services, preventing crisis

2.

Outcomes desired

- Increasing early intervention and prevention by strengthening community offer
- Increasing Mental Health Support for schools' teams
- Update and relaunch emotional/mental health wellbeing toolkit
- Accessible mental health support for children and young people with SEND
- Expanding support for young people with eating disorders
- Development of local leisure services to promote self care
- Launch of emotional health and well being online hub
- Co-production is embedded in everything we do

3.

Current situation

- KPIs review incl. SMART targets for Children & Young Peoples Plan
- CYPP will be reported on quarterly to the Children and Young People's Strategic Alliance (CYPSA).
- System conversation in March 2023 focused in on what needs to be different to effectively support children and young people with complex care and mental health needs including step down placements from Tier 4 provision
- Work underway to look at a system review of the pathway for these children
- CYPSA have agreed to be the Sponsor for this work

4.

Enabling Change

- Reduced referrals into CAMHS single point of entry (SPOE) - % of referrals accepted, % of referrals signposted
- Reduced CAMHS referral to assessment time – 12-week KPI
- Reduced CAMHS referral to treatment time – average time
- Increased uptake of CHUMS provision –
- CYP open to CAMHS with SEND
- SHEU Survey findings demonstrate improved mental health and wellbeing of student population
- Emotional & behavioral health of children in care – decreased average SDQ score.
- Number of Central Bedfordshire education settings who have a mental health lead
- Reduced number of CYP accessing urgent care through emotional well-being and mental health needs (A&E 111*2)

Excess Weight

National & Local Issue:

Too many people living with Excess Weight:

17% of 4-5 year olds (academic year 21/22)

34% of 10-11 year olds (21/22)

and 66% of adults (20/21)

Excess Weight increases the risk of **chronic diseases** incl. cardiovascular disease, type 2 diabetes, cancer & osteoarthritis

Excess body fat is a **factor** in nearly a **quarter of deaths** among people aged over 45 and now contributes to more deaths in this age group than smoking. Moderate obesity **reduces life expectancy** by about 3 years and severe obesity can shorten a person's life by 10 years. This 10 year loss is equal to the effects of lifelong smoking.

The NHS spends around **£6.5 billion a year** (close to 4% of its 22/23 budget) on treating the consequences of obesity. This is forecast to rise to £9.7 billion by 2050. The annual cost to society, including wider economic costs, is around £54 billion, roughly equal to 1-2% of GDP or the total annual funding allocated to schools in England.

1.

Challenges

Obesity was a factor in nearly 4,800 **hospital admissions** in Central Bedfordshire in 2019/20. Obesity-related admissions in the most deprived areas of England are 2.4 times greater than in the least deprived areas.
Excess weight carries significant **economic costs** for Central Bedfordshire, including lost working days and economic inactivity, increased benefits payments and costs associated with NHS treatment and care.

2.

Outcomes desired

- Fewer people living with excess weight
- Reduce rates of excess weight in children were highest in areas of higher deprivation
- Lower prevalence of type 2 diabetes & cancers
- Easier access to healthy food
- Increase physically activity
- More people living with excess weight accessing services to support them
- More professionals feeling confident to talk to people about their weight in a supportive, non-stigmatising way

3.

Current situation

Prevention
- A wide range of opportunities to support people to be physically active
- Active Lifestyle Referral – referral from a GP and other health professionals for smoking/inactivity/weight management
- Development of walking and cycling infrastructure Design Guide encouraging active travel in new housing developments
- Healthy Start Scheme
- Green social prescribing, Community Gardens & allotments and volunteering
- Early years programmes such as Healthy Movers and Physical Activity and Nutrition Coordinators

Treatment and early identification
- Morelife & NHS digital weight loss programme increase with capacity

4.

Enabling Change

Prevention
- Public sector driving production and supply of healthier food options
- Lower density of fast food outlets
- Support for voluntary & community organisations to increase access to healthier foods
- Uptake of healthy start scheme
- Strengthen Design Guide & Local Transport Plan
- Limit the marketing, placement, advertising & sponsorship of unhealthy foods
- Encourage schools & wrap around care to provide healthy options
- Opportunities to be more physically active

Treatment and early identification
- Easier access to integrated services support behaviour change (SPOC)
- Increase confidence of frontline professionals raise excess weight & offer brief advice
- Delivery of a 2 –year specialist programme for people with a learning disability

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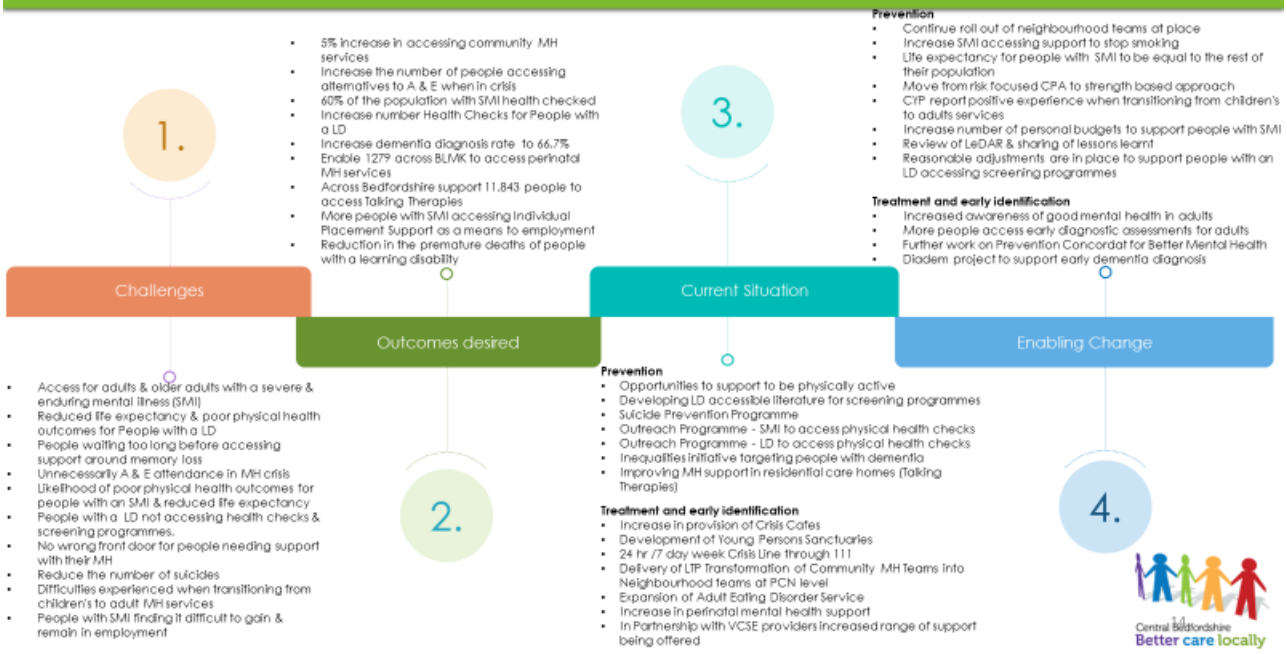
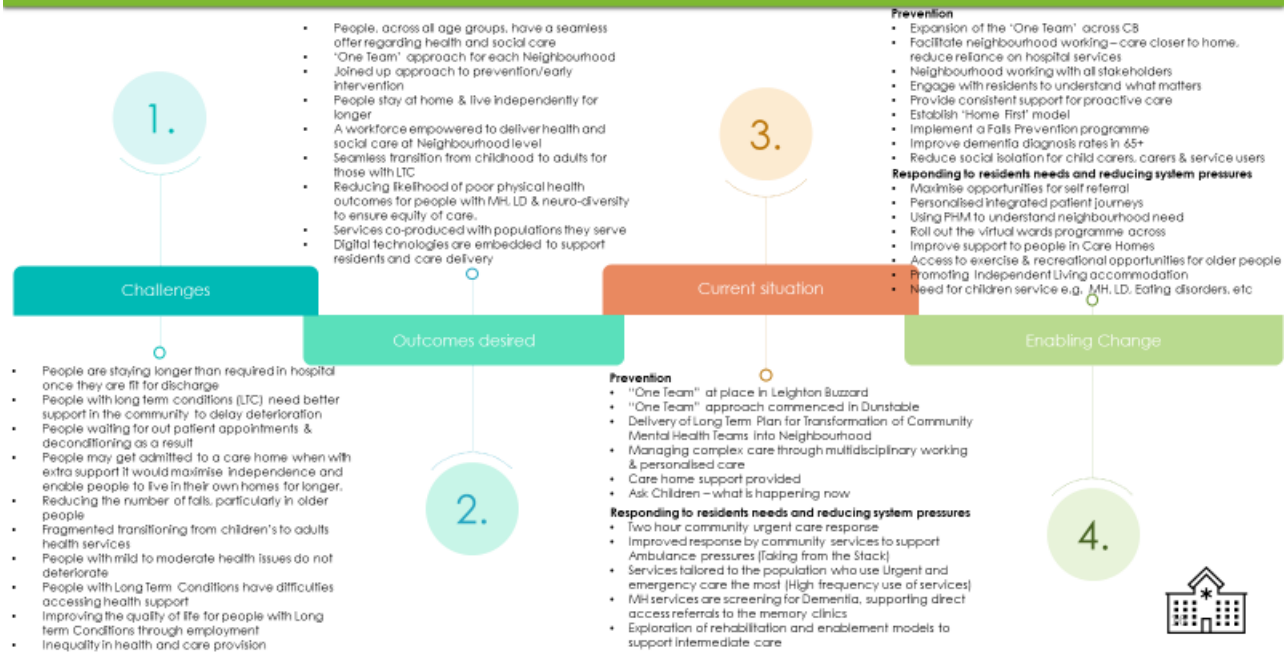
Central Bedfordshire
Better care locally

Mental Health (MH), Learning Disabilities (LD) and Autism



"Out of Hospital Services Working Together" – One Team approach



Key Changes since previous BCF Plan

The BCF schemes are designed to facilitate the delivery of this year's BCF Planning Guidance which priorities:

- A joined-up approach to integrated, person centred services across health, care, housing, and wider public services locally.
- Supporting people to remain independent at home.
- Joint improved outcomes for people being discharged from hospital.
- A reduction in the percentage of hospital inpatients who have been in hospital for than 14 and 21 days.
- Enabling a home first policy.

Key changes since our previous plan are centered on a number of initiatives that enhance our ability to deliver on our ambitions. These include:

- Introduction of a web rostering system providing dynamic scheduling and a clear line of sight around capacity and availability in reablement.
- Workforce model for virtual ward has been reviewed.
- Daily Huddle to support people to remain independent with primary care led community multidisciplinary teams with offering step up/step down solutions, including integrated rehabilitation and reablement services that will avoid or minimise the need to rely on residential or nursing home care. This is now in place for the North and South teams.
- Continuing investment in Independent Living accommodation with Care for older people.
- Agreement to invest in a Falls Prevention Service for Central Bedfordshire.
- Establishing a collaborative multidisciplinary approach to create 'one integrated team' across a Primary Care Network/neighbourhood footprint and refining a model for delivering integrated outcomes for people.
- Continued investment for community referral (social prescribing) using Community Wellbeing Champions in alignment with the Primary Care Networks social prescribing link workers.
- Investment in the Voluntary Sector to support residents who are discharged from hospital on Pathway 0 and 1.
- Communities coming together and supporting each other through local action, neighbours helping neighbours, charity groups (Good Neighbour Schemes, for example) and other voluntary, community and charity responses.
- A hospital discharge protocol for people with housing related issues is now in place, with a single point of contact into the Housing service. The team also work closely with Mental Health Services. The Housing team maintains case control until a satisfactory discharge resolution is reached.
- Bedfordshire Care Alliance has established a number of priorities which will support delivery of timely care. We are continuing the development of our integrated urgent care offer, including an Urgent GP Clinic (located on the L&D Hospital site) and a Bedfordshire and Luton Integrated Urgent Care Service (111, Clinical Advisory Service and GP Out of Hours). An urgent community response offer is in place and provides a 2-hour community crisis response, in line with national requirements for an 8am – 8pm 7 days per week.
- A new approach to supporting People at Home with the joint 2-hour rapid response service with localised teams with flexibility to work across boundaries will ensure people have access to right care, at the right time, in the right place.

Objective 1: To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.

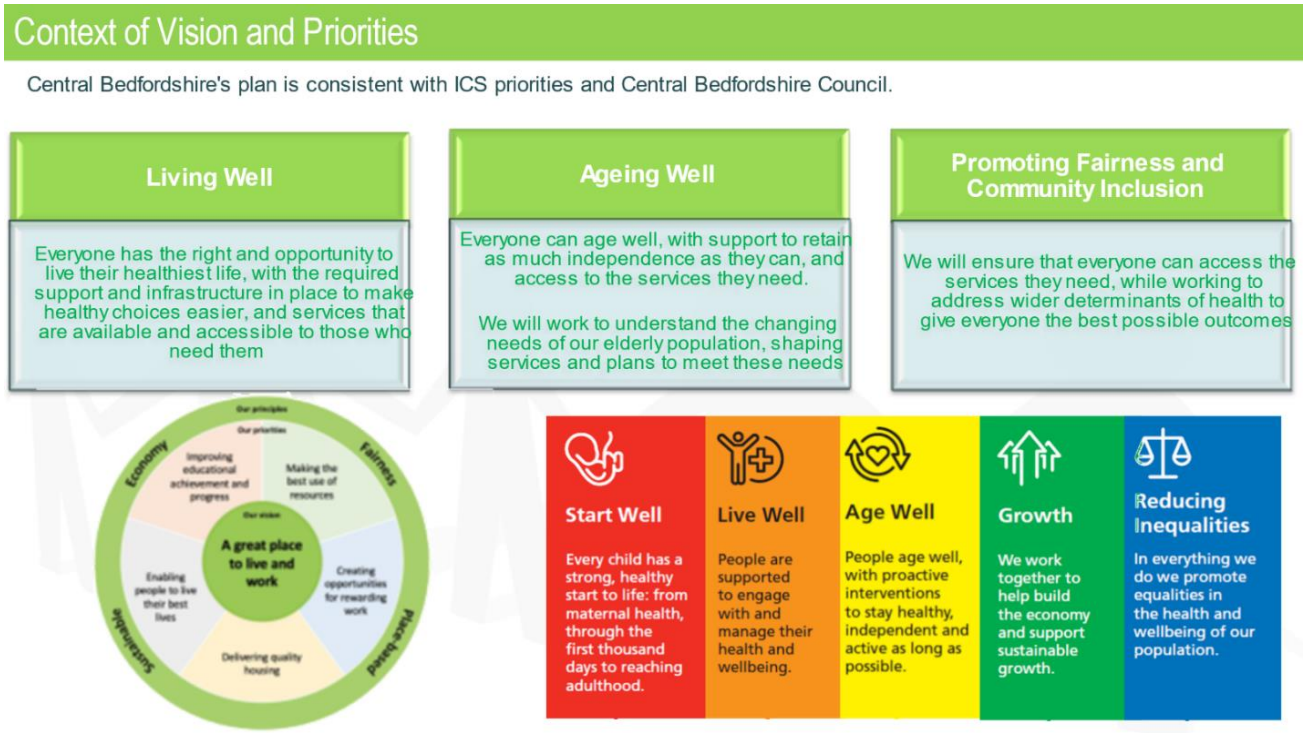
The overarching vision for health and wellbeing is for the people of Central Bedfordshire to have access to good quality, safe, and timely local health and care across our towns and rural areas. This is centred on the integration of health and social care through a whole system approach to improving physical and mental health, so that people can experience "care without organisational boundaries" and 'better care, locally'.

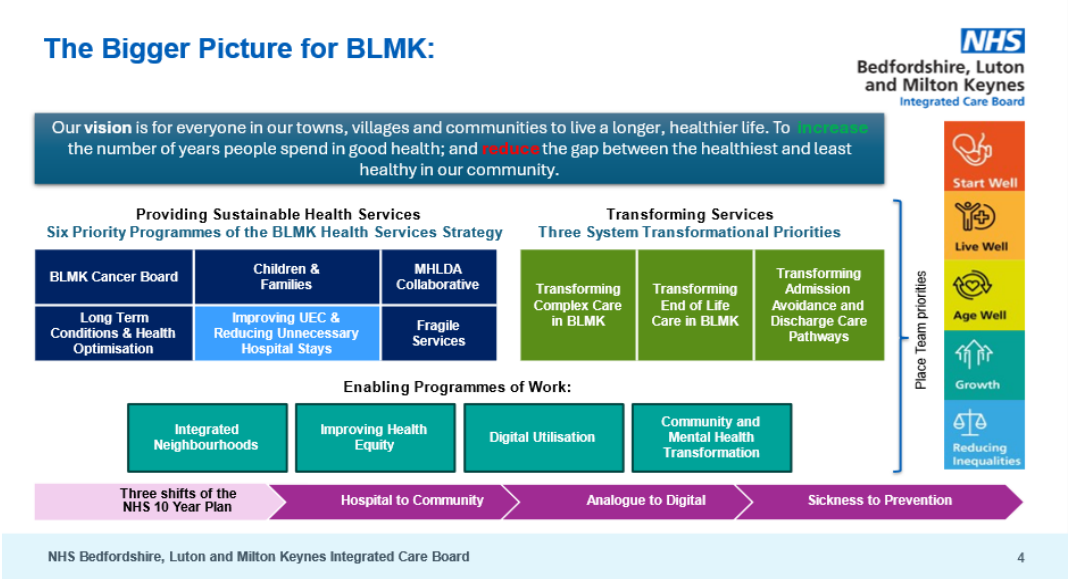
However, with our increasing and ageing population that is set against a background of increasing demand and challenges on resources, we recognise the need for sustainable services. Consequently, there is a systemwide focus on prevention and promotion of self-care. We want to prevent people from becoming ill by encouraging health and wellbeing, reduce reliance on institutions such as care homes and hospitals and help people stay independent in their own homes with a network of local community-based support that can shift the balance of care from hospitals to communities.

Our BLMK ICB strategy sets out our ambition for improving health outcomes and reducing inequalities. Our goal is for everyone in our city, towns, villages, and communities to live a longer, healthier life. It means increasing the number of years people spend in good health and reducing the gap between the healthiest and the least healthy in our community.

The BLMK Health Services Strategy seeks to support individual NHS organisations in fulfilling their statutory duties, whilst driving forward collaboration between organisations, and between them and the populations they each serve.

Our BCF Plan aligns closely with the six priority programmes of the BLMK Health Services Strategy, the Joint Health and Wellbeing Strategy, Place Priorities and Council's Five-Year Strategic Plan.





Collaborative Commissioning

The Better Care Fund is a key mechanism for collaborative commissioning. The schemes aligned to the BCF ensure that the right services are targeted to meet the pressing need for people to receive timely care in the right place. This includes maintaining flow out of hospital, ensuring people with long term conditions or complex care needs are proactively supported, admission is prevented, and deterioration delayed. Specific examples of this include the local authority as lead commissioner of recovery and reablement service, including bed-based options. We have a jointly commissioned carers service and Community and Mental Health Services. We have a collaborative approach to commissioning placements for mental health as well as the wider involvement of the voluntary sector.

We remain committed to using the disabled facilities grant to support residents to remain at home and independent for longer through minor works and adaptations. These range from improved storage, heating and deep cleans up to the provision of specialist adaptations and equipment within the home to reduce the risks of accidents which can lead to emergency admissions, hospital stays and an escalation of care needs.

Central Bedfordshire Council is working with system partners to build a Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative, to ensure that all elements of the mental health system and pathways work together in joined up ways. The collaborative launched in 2024/25 and is currently under consultation on a staffing resource structure, with a view to launching this in 2025 to support ongoing delivery. As part of this there is an ongoing commitment to ensuring People Participation (Service Users and Carers) is a core and central part of the way of working, both in the MHLDA Committee that has been established (formal committee reporting directly to the ICB board) and in the resourcing structure.

We have adopted a collaborative approach to planning and delivery of services where appropriate. To support neighbourhood working, ELFT Therapy teams based in South and Mid Bedfordshire have aligned under one locality manager to deliver therapy services across Central Bedfordshire. These teams consisting of Occupational Therapists and Physiotherapists are supported by a cohort of assistant practitioners and rehab support workers. East London Foundation Trust are working towards implementing four neighbourhood teams across Central Bedfordshire. There is an ambition to develop an integrated rehab and reablement offer across health and social care for Central Bedfordshire in 2025/26.

By moving to a more integrated service delivery model there will be improved response and coordination of intermediate care in the community and pathway 2. Using an in-reach model to support acute providers to identify those most appropriate for pathway 1 (Intermediate care).

Further benefits include:

- Reduced variation in patient experience.
- A larger team providing increased resilience with opportunities to identify duplicated roles and functions.
- Aligned clinical and governance functions that will support improved quality and outcome for people against pathway 1 intermediate care across Central Bedfordshire.
- Maximising capacity to support prevention and admission avoidance, ensuring more people are going home first.

Activity that supports people through pathway 1 is linked to the headline metric, ‘long-term admissions to residential care homes and nursing homes (65+)’.

There is ongoing work through the Pathway 2 project group covering Bedfordshire that is focused on operational and process improvement, supporting improved flow, efficiency and quality. System partners across ELFT, CBC and ICB have been working collaboratively with BHT and in conjunction with Bedfordshire Care Alliance (BCA) to develop a proactive in reach pilot project that will run for 6 weeks. The pilot will consist of a team across community, local authority, community beds and discharge planners to provide onsite real time triage and initial assessment for medically fit for discharge identified for either Pathway 1 or Pathway 2. The pilot hopes to identify more appropriate pathways

with an emphasis on home first with Pathway 1 and reduce delays in discharge. Impact will be measured through the BCA and project team and the outcome will further inform the overall Pathway 2 project.

The Pathway 2 project is also looking at the commissioned bed capacity and configuration to determine if there are any gaps and if the supply of commissioned provision meets the demand seen locally. Supporting people with dementia and complex needs has been identified as a gap and this is an area the project group is currently reviewing to ensure we commission the right provision that meets the needs of our local population and reduce stay in hospital, improving outcomes for residents.

There is also a new approach to supporting People at Home. Our partners, East London Foundation Trust (ELFT) and Cambridgeshire Community Services (CCS) are bringing their unscheduled care teams together through integrated leadership and an unscheduled care co-ordination hub. This provides co-ordination of response to the stack and call before you convey, establishing localised teams that can offer flexibility to work across boundaries.

Falls Prevention

Preventing falls in older people is a national and local priority. Falls can have a negative, sometimes life changing consequence for an individual in terms of injury and loss of independence, and there can be significant costs to the health and social care system.

For the past two years improving the Falls pathway has been a priority workstream within the Bedfordshire Care Alliance (BCA) Complex Care and Frailty Programme with the aim of ensuring a consistent and integrated falls pathway offer within each local authority area within BLMK.

Plans are in place to set up a clinically led Falls Prevention Service in Central Bedfordshire forming part of the Community Health Service (CHS) provided by ELFT. The aim of the service is to understand the reasons why a person has fallen, provides multifactorial assessment and individualised care planning with interventions to reduce the risk of future falls and injury. The service will provide a single point of access into the falls pathway and clinical triage ensures people receive input appropriate to their level of need. Interventions are timely and the service works in an integrated way with other service providers involved in the fall's pathway.

CHS will work in an integrated way with Central Bedfordshire's existing Urgent Home Care Falls Response Service (UFRS) and level one Strength and Balance programme to provide a comprehensive falls prevention offer. The detail of the integrated working between health and social care needs to be developed, but this would include the triage and assessment process, interventions provided and outcomes.

The Interface Frailty Service providing Same Day Emergency Care (SDEC) for the frail population with access to a 'Silver phone' providing geriatrician support to professionals in general practice and the community to support complex case management of ambulatory sensitive conditions and avoid unnecessary hospital admission has been extended to care homes. The services help to divert even more patients from the Emergency Department and supports people directly from community.

Objective 2: To support people living independently and the shift from hospital to home – including help prevent avoidable hospital

admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of residence); and reduce the proportion of people who need long-term residential or nursing home care.

Integrated Neighbourhood Working (INW)

The Neighbourhood Health Guidelines for 2025/26, published by NHS England, provide a framework to transform health and care services at the community level. These guidelines aim to address the increasing prevalence of complex health issues and the fragmentation within the current system. The overarching goal is to foster healthier communities by enabling individuals to lead active, independent lives with improved access to integrated health and social care services.

Our approach to ensuring people receive the right care at the right time is centred on our vision and ambition for a 'Place based' approach with better care locally. At its heart, is an ambition to secure access to the right care, in the right place and at the right time. Central to this, is a drive for transformational change across health and social care based on integrated and seamless care pathways at a neighbourhood level. Care should be coordinated around an individual's needs with prevention and support for maintaining and maximising independence at its core.

To secure this vision, we have been implementing more joined-up services with primary, community, mental health and social care teams working across our neighbourhoods. Our ambition for integrated solutions and timely care, of course extends beyond health and social care. We wish to create an all systems partnership which includes housing, as well as working with Independent, Private and Voluntary organisations.

Our testbed for this approach is our "Working Together in Leighton Buzzard" Collaborative Model, which builds on existing integration initiatives and is underpinned by a population health management approach. It provides an integrated person-centred focus on a community/population at a Primary Care Network/neighbourhood footprint. This approach ensures an integrated approach that is responsive and has an equal focus on community and mental health services to support people to manage their health and social care issues in the community. Importantly broadening the scope for service integration that involves all partner organisations, including third sector organisations, and incorporates the views of users and carers. Key delivery areas for this model of care include:

- Promoting independence, enabling people to remain in their homes where appropriate.
- Reducing the need for people to move into long term residential and nursing homes.
- Reducing avoidable admission / re-admission into hospital.

Admission avoidance, particularly in relation to preventable ambulatory care conditions is a key focus of the multidisciplinary working approach. To deliver the full continuum of health and social care support, using population health profiles, MDTs can identify people who would benefit from anticipatory care planning to support those most at risk of adverse health outcomes. For example, those who have

complex emotional and mental health problems; those with long term conditions; the population who are frail and those who are high intensity users (including people on multiple waiting lists) or at end of life. This is our precursor to the Fuller Stocktake and a place plan has been developed with stakeholders to roll out Integrated Neighborhood Working (INW) across Central Bedfordshire and to all four defined neighbourhoods. This will be supported by Population Health Management (PHM) supporting a robust evidence base for each neighborhood that focuses on neighborhood health.

Plans are in place to review the existing 'working together' and virtual MDT models of care and agree how we can measure impact on what is being delivered locally. Further work has gone into developing our plans for Integrated Neighbourhood Working across Central Bedfordshire that have been co-designed with system partners and stakeholders.

Keeping Well Frailty Clinic

A Keeping Well Frailty Clinic is delivered as part of a multidisciplinary team-led neighbourhood offer. The clinic seeks to establish a local proactive care model to deliver seamless and integrated services for the frail/elderly population of Chiltern Hills PCN. The aim is to run a comprehensive multi-disciplinary clinic with Primary, Community, Secondary and Social Care services represented with an Acute Geriatrician working with the team. The Grove View Integrated Health and Care Hub has been the initial test site for these clinics.

The clinic model aims to:

- Proactively identify and care for frail/elderly residents at every stage of the pathway.
- Have one integrated health and social care multidisciplinary team at the heart of the service.
- Replace the other local fragmented, independently operating, and often duplicated services.
- Provide a Comprehensive Geriatric assessment in form of face-to-face and/or virtual assessments.

People who are eligible to access this service will be identified in line with the Anticipatory Care Framework (2022) and may include:

- Residents with comorbid long-term health conditions.
- Those with a moderate or severe Frailty score.
- Frequent A&E attenders.
- People who have had two or more emergency admissions in the last year.
- Those identified to be at risk of emergency admission.

A personalised care and support plan will be proposed and agreed with the person. Patient satisfaction will be an important indicator of the success of the clinic, which will aim to provide care that supports what matters most to each person. There is a planned review of the Keeping Well Frailty Clinic, and the final report and recommendations are expected Apr-25.

Alongside all these initiatives are carers. We recognise the important role of carers in enabling their loved ones or cared for person to stay independent at home for longer. Identification of Carers, provision of enhanced information and advice, signposting, and promotion of wellbeing are central to our approach to supporting carers.

Transforming admission avoidance and supporting community response

For 2025/26 there are a number of overarching ICB priorities within the BLMK Operational Plan which will support with delivering key focus areas for urgent same day primary care and urgent community response, which include transforming admission avoidance and discharge care pathways, as well as complex care at Place. The BCF additionality to the ELFT service provision will support a number of improvement opportunities across Bedfordshire and Luton, including recommendations from an ELFT crisis care pathway review which will be considered and progressed throughout 2025/27.

In addition, the ICB has been working with regional colleagues and has now received the A-Ted (Alternatives to ED) reports and is undertaking an exercise to extract the opportunities for improvements in-hospital, out of hospital and alternatives to admission at place and inform plans for 2025/26.

In Q1 we will have an action plan to address some of the opportunities. Delivery will be monitored through the UEC planning and Assurance Group and at the Central Bedfordshire Joint Leadership Group. Proposed actions for Central Bedfordshire will ensure avoidable admissions and care closer to home remain a priority, expand opportunities for joined up support and consistency of approach in the community and the acute around frailty assessments and scoring, strengthening Street Triage and exploring the Basildon Model for mental health crisis, developing a COPD-specific pathway into the Urgent Community Response Team.

A planned ICB review of services will explore new opportunities to streamline pathways and support urgent and emergency care pathways (UCCH, Virtual Ward, 111, GP out of hours and UTCs). This will inform a longer-term commissioning strategy and reduce inefficiencies in the system. The timelines for completion are unclear but there will be a strong focus in Q1 and Q2.

Timely access to reablement services is a key duty of the Care Act which also includes provision of universal assessments for all those in need of care and for carers. Central Bedfordshire residents continue to receive up to six weeks reablement services with access to aids and adaptations to promote independence and help sustain people at home.

In addition, Raizer Chairs have been deployed into our Care Homes as part of a pilot project. These chairs are used to lift residents when they fall, reduce the length of time spent on the floor and reduce the need for conveyance. We have implemented Falls Champions, alongside a hydration programme which can help to reduce the risk of falls. We are implementing a Falls Prevention Service for Central Bedfordshire in partnership with ELFT.

Central Bedfordshire has set up a pilot, GaitSmart' (Dynamic Metrics), a sensor-based digital technology that monitors limb movement and can be used to assess problems with gait for older people at risk of falling. Sensors are placed on the pelvis, thigh and calf and measurements are taken while walking to identify any problems with gait. The test can be completed in 10 minutes and can be done by a healthcare assistant following the necessary training and support structure being in place.

The use of GaitSmart in the services will provide or enhance existing strength and balance programmes / therapy intervention with the aim of improving people's empowerment, motivation and gait outcomes, thereby reducing falls and increasing the options available to people for intervention.

Urgent Community Response (UCR)

The delivery of Urgent Community Response (UCR) activity across Central Bedfordshire continues to support improved outcomes for people by providing an urgent response to those at risk of hospital admission. The service uses alternative pathways to enable residents to remain at home, reducing

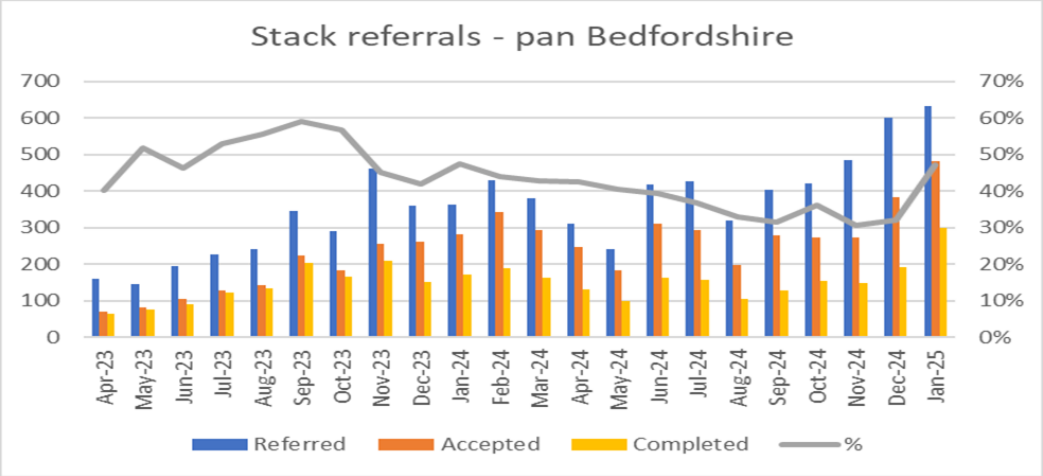
pressure on acute services. The UCR team works closely with care homes and primary care to support both timely responses to referrals and following the required intervention facilitated step down to appropriate services to support people to both meet their immediate health needs and facilitate proactive health management interventions.
The data below demonstrates the service has consistently met the 70% 2-hour national response target, even within the months where there has been a significant increase in referrals.

Metric ID	Performance Indicator Description	Target	2023/24 Baseline	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
RR1	Number of 2 hour response requests received	G 90% A 85%	2451	196	180	304	254	246	284	314	248	200	251
	Of which were met within the 2 hour target		2382	185	179	273	240	232	270	286	234	174	223
	%		97.50%	94.40%	99.40%	89.80%	94.50%	94.30%	95.10%	91.10%	94.40%	87.00%	88.80%

We are commencing a review of our operating model/ processes with system partners to understand if we can identify opportunities which will generate additional unscheduled care capacity overall.

Unscheduled Community Care Hub (UCCH)
The Bedfordshire UCCH has been set up and operating out of the Poynt, Luton. The UCCH brings together teams from the community, BHFT and EEAST to work in a multidisciplinary way to support clinical decision making and take subsequent actions to further reduce the need for acute service provision and instead utilise available alternative pathways. The UCCH acts as a coordinating function for community rapid response teams, virtual wards as well as identifying patients directly from the ambulance stack, ensuring the unscheduled resource is utilised as effectively as possible.

Ambulance stack
A key component of the unscheduled care hub is to support the East of England Ambulance Trust by visiting people that have been assessed as appropriate for a community provider to attend as opposed to an ambulance. This approach releases ambulance capacity back into the system for higher risk patients and provides an opportunity for community providers to intervene and provide an alternative pathway as opposed to a potential ambulance conveyance and potential admittance, which promotes better outcomes for people.
There has been an improvement in performance over the last 3 months in the number of patients deemed as completed (ambulance averted) via the stack process as set out below (Bedfordshire wide data). This is attributed to some changes made within the stack management process which provides a higher level of management support, integrated leadership and overview that facilitates positive risk management of patients, together with an increasing level of staff competencies. In January 2025 the Bedfordshire stack had the highest number of completed stack referrals in the East of England, refer to graph below.



Call before you convey

The next key component of the UCCH will be the introduction of a call before convey hotline. This will be a single number for the whole of Bedfordshire for ambulance crews to call through to; to discuss any patient they are considering conveying to hospital. The ambulance teams will be put through to a BHT consultant for advice around alternative pathways prior to conveying the patient. This process will be utilised for appropriate patients and will further supplement the already existing silver phone line which will remain in place for frailty patients which will also be accessed through this one dedicated number.

Facilitating Early Discharge Planning and Patient Flow

PA Consulting undertook a diagnostic review of system costs aligned to the Better Care Fund in November 2024 and the outputs will be used to ensure the system maximises value for money on our existing commitments, especially where it concerns discharge pathways (P0-P3). It was found improvements could be made in:

- Avoidance of admission and subsequent discharge.
- Redesigning pathways to increase Pathway 0 and reduce Pathway 3 discharges.
- Joining up fragmented pathways to reduce delays in discharges, particularly to Pathway 2.

Through the Bedfordshire Care Alliance, we are exploring ways to reduce unnecessary Pathway 2 bedded care and length of stay (LoS) across all pathways, enhancing 24-hour care at home to support the assessment for short and longer-term needs in the patient's own environment, which includes the delirium pathway funded through BCF. There will be opportunities to reduce the need for long-term care/placements within Central Bedfordshire. This Pathway 2 programme will summarise options in Quarter 1, informing longer-term plans and actions.

It is important to recall the Integrated Discharge Hub, a multi-agency team has been established for a number of years, leading to strong working relationships both with internal and external partners. A number of joint roles, including the Integrated Discharge Hub Lead, Placement Officer and mental health social workers are funded through BCF. These established and collaborative relationships enhance the team's working methodology, which includes a continuous cycle of improvement, built on a 'plan, act do review' process to ensure the team and services continue to flex and develop, to meet demand and patient needs.

Plans for 2025/26 are supported by increased data oversight. Central Bedfordshire uses a range of data sources to understand themes, trends, and demands placed on the service. For example, the DART team

have developed a data set which identify patient's length and complexity of stay. The information is used to identify patients who will require a multi-disciplinary approach to secure their safe discharge. In addition, it has been recognised that the internal processes from the wards to the Discharge Hub required revisiting. As such, the Notification of Discharge (NOD) documentation has been refreshed, and the documentation is being piloted. Additionally, a new referral and assessment form (RAF) is being trialed, with the aim to expedite decisions reducing the amount of correspondence needed to inform placement decisions when considering discharge to assess beds.
Access to the Heath Trust electronic record system, called NERVE CENTRE, has been granted to DART social care team. The read-only access will facilitate multi-disciplinary working, as the team will be able to immediately access up to date information, which will inform and enable proactive working and timely decision making. NERVE CENTRE access will enable the team to access live information relating to a patient's medical status, any planned or completed interventions, assessments, and treatments. Nerve Centre will also be supporting the BCF DRD Metric.
The DART Team continue to work closely with our VCSE Partners to ensure safe and effective discharges and post discharge support. The VCSE are critical Partners in timely and effective discharge. The Age Concern contract is a Bedfordshire wide agreement, funded through BCF, provides a Hospital Meet & Greet, and Aftercare Service to ensures that individuals are supported in the short-term following a stay in hospital, attendance at Accident and Emergency or following a planned surgical or medical procedure as an inpatient or outpatient.

The Luton and Dunstable Hospital Discharge Lounge is supported by a resettlement service offered by Red Cross and funded through BCF. The service provides a comprehensive range of support from meeting the patient on ward through to transportation home and settling at home, ensuring a safe environment, including a home risk assessment ensuring suitable heating and food available, shopping, and a transport service both for users and/or other necessary items e.g. medication and mobility aids to enable a swift and effective discharge of patients. Support will continue to be available for the 72 hours following discharge to ensure all is well and minimise the risk of readmittance. Signposting and supported referrals to ensure ongoing support is also available where appropriate.

VCSE partners are key partners at the Patient Tracking List (PTL) meetings. Discussions relating to discharge plans are and will continue to be informed by the interventions which have been commissioned.

The Virtual Ward programme continues to be an integral part of the Urgent & Emergency Care (UEC) system. There is national and regional commitment to the ongoing growth of Virtual Wards and emphasis on the importance they play in reducing hospital admissions and supporting early discharges. Virtual Wards have been operating since October 2022 with the staffing model and bed numbers increasing significantly during this time with wards now in place for frailty and respiratory patients. Frailty activity is provided in collaboration with the Acute Frailty Team from Bedfordshire Hospitals NHS Foundation Trust working in partnership with East London Foundation Trust.

The primary aim of this service is to support acutely unwell patients over the age of 65 living with frailty, providing care in their own home as an alternative to hospital admission. Eligible patients are referred from primary and secondary care, paramedics and care homes.

There have been significant benefits from the rapid response team working alongside newly appointed Advance Clinical Practitioners and consultants in relation to Virtual Ward activity. This joined-up working has enhanced the skills and confidence of staff when undertaking UCR activity, which has supported the

team to manage complex patients, who may have previously been referred to the acute service provision.

There are plans in place to expand the capacity of virtual wards across Central Bedfordshire in 2025/26 with the two virtual wards covering Bedford and Luton (south Central Bedfordshire) expanding to provide better coverage.

Remote technology enables the collection and monitoring of key vital signs to support the care provision and facilitate decision-making and/or escalation. Patient data captured by the equipment is accessible to relevant clinical/admin teams via an interactive (web-based) dashboard. Clinicians routinely monitor patient data and intervene when their readings are of particular concern. Consultations with health care professionals can take place over the phone, online or via video link. The equipment provided includes Bluetooth wearables such as BP cuff, sats probe and thermometers.

The national 'Delivery plan for recovering urgent and emergency care services' (2023) outlines the need for providers to use Point of Care Testing (PoCT) devices within Virtual Ward services. PoCT enables the delivery of high quality, accessible diagnostics at the patients' bedside, improving clinical decision making and enhancing patients' healthcare experience through quicker access to diagnostics. Within Central Bedfordshire there has been investment into the required machines to support clinicians.
The benefits include:

- Timeliness: POC tests provide immediate results, allowing quicker decisions about treatment and care. This is crucial for frail patients who may have conditions that require rapid intervention.
- Convenience: These tests can be conducted in a variety of settings, including the people's home.
- Reduced Stress: By minimising the need for travel and long wait times, POC tests reduce stress and discomfort.
- Improved Patient Management: Immediate test results facilitate prompt changes to treatment plans if necessary.

There is an ambition to develop a Gold Virtual Ward covering Bedfordshire focusing on end of life that can be accessed from both a step up from community and step down from hospital, delivering face-to-face reviews and prescribe or support medication so people can stay at their place of residence. The aim would be to improve outcomes for residents and families and reduce hospital admission / re-admission.

In 2025/26 the Integrated Discharge Hub will work collaboratively with health and allied health colleagues to develop strengths-based discharge plans which are culturally sensitive, ensuring culturally sensitive, anti-discriminatory and anti-oppressive practice is core to any delivered interventions.
A new project plan, supported by the Multi-disciplinary Discharge Team, will be progressed in 2025/26. The DART will be designated to wards, to raise the profile of team amongst acute colleagues and ensure that social care interventions planned at the earliest point of care. The increased presence in the clinical setting (wards) will enhance decision-making by ensuring interventions from a social model are utilised proactively. The project aim is to reduce the length of stay of patients who have been deemed to be medically optimised through to their discharge date. This is a notable and much needed change in practice, which will see the team working with patients from the point of their admission, ensuring proactive advanced planning, in order to reduce the length of stay.

To support patients' discharge experience, there is a plan in train to review and co-produce discharge information packs with patients who have been discharged from the hospital, ensuring the information contained is helpful.

The DART teams' ambition for 2025/26 is to ensure patients' discharges are supported by the same professional, promoting relationships through the development of trust. The requirement for patients to relay their narrative to professionals will be reduced by this consistent approach. Moreover, taking an evidence-based approach to a patient recovery process will reduce the risk of over-prescribing care. This initiative will be supported by staff members who will be trained as trusted assessors for small pieces of equipment, supporting effective recovery, and reducing the waiting time for occupational therapy assessments.

Intermediate Care

There are six priorities under the Bedfordshire Care Alliance (BCA) and Pathway 2 Intermediate Care forms one of those six. The Pathway 2 (P2) project aims to enhance bed-based step-down intermediate care services across Bedfordshire and Luton. It provides short-term (up to 6 weeks) health and social care to adult's post-hospital discharge, enabling rehabilitation, reablement, and recovery. The overarching goal is to reduce hospital bed occupancy by ensuring timely transitions into P2 placements and optimising community therapy services.

Key areas of focus include:

1. Reducing Delays in Discharge
    - Minimise waiting times for P2 placements post-medical optimisation.
    - Improve patient experience by moving people closer to home, reducing hospital-acquired risks.
    - Enhance emergency care services by freeing up hospital beds and improving ambulance offload times.
2. Optimising Intermediate Care Services
    - Review the number and configuration of P2 beds to align with local needs.
    - Assess whether the current commissioning model (block vs. spot purchase) is cost-effective and responsive.
    - Explore the role of NHS specialist provision and estate planning to support complex care needs.
3. Enhancing Service Models and Processes
    - Streamline referral processes to reduce waiting times at each stage of care.
    - Strengthen the joint commissioning approach between the NHS and local authorities.
    - Leverage virtual wards and alternative care pathways (P0/P1) to support earlier discharges.
    - Improve clinical and social care staffing capacity to support patient transitions effectively.
4. Expected Outcomes
    - Maximising independence and minimising unnecessary delays in accessing P2 care.
    - Reducing hospital readmissions through improved rehabilitation and reablement services.
    - Enhancing patient flow in acute hospitals, leading to improved Emergency Department (ED) performance.
    - Reducing average waiting times for P2 discharge from 10 to 5 days.
5. Implementation Plan
    - Business Case Development (Apr-25). Ensuring right type and number of beds to meet clinical need – focus on dementia pathway.
    - Approval and sign off from ICB Operational Group, Local Authorities, BCA Committee, and ELFT CHS (Apr/May-25).
    - Operational Improvements through process reviews and new efficiency measures.
    - Set up a pilot project to test a proactive in reach model in Bedford (Apr-May 2025). Developing an integrated complex care in reach MDT to improve flow from hospital and identify discharge plans at an earlier stage.

- Stakeholder Engagement & Workshop (January-March 2025) to refine priorities. Transition plan to left shift activity across P0-3.

This project initiative represents a critical step towards integrated, person-centered intermediate care, ensuring efficient hospital discharge processes, better patient recovery, and improved health outcomes across Bedfordshire and Luton.

In terms of capacity, we can support all residents through a mix of commissioned and spot purchase placements. We are improving waiting tines for transfer of care through our pathway 2 transformation programme as above. As part of the pathway 2 development, we will be reviewing the optimum number of therapy staff to support rehab and prevent deconditioning.

We are developing a transition plan for P0-3 with a focus on enhancing our home first offer. This includes reviewing the optimum number of registered and unregistered staff for community P1 pathways to support people to remain independent and reduce deconditioning following discharge from hospital, through UCR pathways and through prevention work. We are integrating our rehabilitation and reablement offers across health (ELFT) and adult social care. The overall vision is to improve residents' experience and outcomes for people accessing intermediate care pathways, whilst improving flow from hospital, preventing unnecessary admissions and enhance integrated working. This integrated model will consider how we implement neighbourhood working, digitalization and how we bring these together from across health and social care and how we link the falls service into this model and new way of working.

Central Bedfordshire Council has implemented news ways of working to enable more timely monitoring of discharge activity. This includes data analysis for reducing length of stay for people in pathway 1 (those who will be able to go home on discharge with some care) pathway 2 (discharged to intermediate care) and pathway 3 (person with complex needs and requires nursing home care). With a combination of changes to processes and ways of working a reduction of 3 days in length of stay will significantly reduce the number of bed days across these pathways.

Intermediate care activity aims to reduce the time from when a person is assessed as being medically optimised and ready for discharge to the actual discharge day. This links to the headline metric, 'discharge delays – on a month-by-month basis'.

Phew!

The Phew! App, continues to be used to manage patient flow through the community D2A beds, as well as providing a single shared live view of available capacity by location. This tool is invaluable to ensure patients are progressed through the community beds in a timely way, ensuring capacity is maximised and maintaining flow through the hospital. We continue to develop the app to provide a greater level of granularity, particularly in reporting. Current developments underway include:

- Reporting of Reserves/Waiting Beds Patient times
- Data reporting
- Month by month occupancy / activity / flow reporting in aggregate and by provider
- Month by month Length of stay reporting in aggregate and by provider.
- Able to report on monthly and aggregate discharge data to understand outcomes.
- Report on service users who end up in Pathway 2 but weren't appropriate i.e., should have been discharged on Pathway 1, but capacity wasn't available.
- Reporting on reason for spot purchase i.e. refusal of beds vs bed availability vs mix of service user's vs specific clinical need for assessment of commissioned cohort.

- Reporting by need / complexity (drop down list rather than free text)
- Bed cost recording and reporting for spot purchase beds.
- National intermediate care reporting as per guidance

Mental Health
The BCF programme has for a number of years, facilitated the joint commissioning of the East London Foundation Trust (ELFT), Mental Health contract, accountable for the Community Mental Health Transformation Programme.

Through 2025/26 there continues to be a focus on the ongoing development of Community Mental Health services to continually review and improve service provision. The Community Programme Board oversees this work, and its membership is comprised of service user representatives, operational and clinical leads, the voluntary sector and NHS commissioners.

Key work streams have been developed in response to local and national priorities:

- Core Clinical offer – aligned to Quality Improvement (QI) methodology, this is the continuous review and improvement of our core clinical services to ensure they are meeting the needs of the communities we serve.
- Complex Emotional Needs (CEN) – ensuring the provision of a dedicated function for CEN patients linked to a core mental health service, with service delivery driven by experts with experience, ensuring trauma specific support, and working with the VCSE partners.
- Assertive/Intensive Outreach – aligned to national priorities linked to high profile events in Nottinghamshire, ensuring our services meet the needs of our most vulnerable patients in the community.
- Older Adults – Reviewing the service model and workforce to meet demands to continue to ensure adults and older adults with moderate to severe mental illness (SMI) are able to access mental health care, where and when they need it, and are able to manage their condition or move towards individualised recovery on their own terms, whilst supported by their families, carers and social networks, and the local community.
- Workforce – ensuring we have the workforce in place to deliver the services required by our patients.

The programme is built on the ethos of 'knowing our community,' placing co-production with service users and carers central to decision making and transformation, to inform and address inequalities in access, experience and outcomes. BCF, HDF and S75 Agreement remain critical enablers of the mental health programme.

At the core of Mental Health services ethos is supporting people to stay well in the community and outside of hospital settings. The Community Mental Health Transformation Programme is a continuous improvement programme ensuring our services support residents to access the care they require in their home and/or local communities. A key focus throughout 2025/26 will continue to be supporting people and meeting their needs outside of hospital settings.

Across Inpatients, Crisis and Community Services there continues to be a whole system focus on patient flow through inpatient services, supported discharge and admission avoidance activities, to address this challenge. This aims to ease pressures, support more patients without requiring inpatient stay, and for those who are admitted supporting them to access ongoing care and support in the community as soon as it is safe and appropriate to do so.

Through a concerted and ongoing effort across the whole MH system, huge progress has been made over the past 12 months through 2024/25 towards this ambition e.g. use of out of area private inpatient beds has reduced from 24 to 5 as a key highlight. However, there is further work to be done still in the coming year, as despite this demand continues to exceed capacity. At the time of writing (March 2025) we are continuing to see high demand for inpatient mental health services in excess of capacity, with ELFT wards operating at full capacity, the use of additional out of area private inpatient beds (albeit at reduced rates than 2024/25), use of step-down beds (Destiny), and pressures in A&E.

The BCF/HDF programme in Central Bedfordshire supports the funding of two services in East London Foundation Trust (ELFT), the provider of Mental Health services in Bedfordshire and Luton:

- Discharge Team
- Mental Health Step Down Beds (Destiny Beds)

Discharge Team

Discharge Hub is one of a series of critical intervention in place supporting flow through the MH system. Flow directly impacts on:

- The front door (patients waiting in A&E/hospital for MH beds)
- Admission – to ELFT B&L inpatient beds, to private out of area beds, to step down beds
- Length of stay and delayed discharges (Clinical Ready for Discharge, CRFD, delays)

Through constant MH system wide efforts to improve flow through the year, of which the Discharge Hub is critical part, we have seen:

- Reduction in private bed usage across the year.
- Reduction in step down bed usage across the year.

Despite this improvement:

- ELFT inpatient beds continue to be fully utilised.
- We continue to have patients waiting in A&E/hospital.

In short, despite progress demand continues to exceed capacity.

Whilst the position is significantly improved through the year, there is further work to do, in particular:

- Bed occupancy is high.
- Patients continue to wait in A&E/hospital. There is a risk these could translate to private bed usage and spend also.
- We continue to have private bed usage.
- We continue to use Destiny beds.
- Additionally, there are high numbers of delayed discharge days in Destiny in particular (often housing related).

Through repatriating people from out of area private beds to in-area/home, this improves quality of service, patient experience and reduces system costs. Through 2025/26 the Discharge Hub will continue to be a core part of ongoing efforts to support flow through the MH system, target to sustain and improve on the current position as part of the new way of working.

Funding is used to provide Destiny beds, which are step down beds from Mental Health inpatient beds. As detailed above under “Discharge Team”, step down beds are one of a series of critical interventions in place supporting flow through the MH system. Flow directly impacts on:

- The front door (patients waiting in A&E/hospital for MH beds)
- Admission – to ELFT B&L inpatient beds, to private out of area beds, to step down beds
- Length of stay and delayed discharges (Clinical Ready for Discharge, CRFD, delays)

Per "Discharge Team" as of April 2024 there was significant excess demand for MH inpatient beds than available capacity. The provision of step-down beds supports the MH system to discharge sooner patients who no longer require acute admission but do require ongoing care. Were these beds not available patients would likely continue to reside in MH inpatient beds with increased and avoidable length of stay and placing avoidable pressure on flow and capacity. This in turn would further impact pressures on flow, likely resulting increased numbers of patients being admitted to out of area private beds (high cost, lower quality/experience) and/or increase those waiting in A&E/hospital.

Through the work of the MH system and constant focus on flow throughout 2024/25, we have made measurable impacts in reducing the numbers of private beds through 2024/25 and step-down bed usage.
Through 2025/26 the MH Step Down Beds will continue to be a core part of ongoing efforts to support flow through the MH system, target to sustain and improve on the current position as part of the new way of working.

Primary Care Link Workers work alongside GP practices to support patients with lower-level mental health support requirements within primary care and the community. By providing access to mental health support locally this helps to prevent people who would otherwise be at risk of their mental health deteriorating and who may require onward referral to secondary mental health services, supporting the BCF "sickness to prevention" agenda. This is aligned to the BCF aim to "support people living independently and the shift from hospital to home".

Psychiatry Liaison Service (PLS) provides timely mental health input/assessment to patients in a hospital setting who are at risk of admission. This is a 24/7 mental health offer in A&E departments, where mental health patients can be quickly assessed if they require a mental inpatient admission or can be supported in the community. For those who can be supported without a mental health admission, PLS is part of a wider Crisis offer for Mental Health patients and work across the pathway and services to arrange ongoing support for people to access care outside of a hospital setting in the community and their homes, typically with Crisis and Community Teams, as well as the VCSE e.g. via Recovery Lounges. This helps to prevent avoidable admissions to both an acute hospital setting and acute mental health inpatient setting. PLS also works with acute hospital teams for mental health patients who are admitted for physical health needs to ensure they have ongoing support and care during their admission, which supports effective flow and discharge.

The BCF programme has facilitated the joint commissioning of the East London Foundation Trust (ELFT), Mental Health contract, accountable for the Community Mental Health Transformation Programme. A review of CHS and Mental Health services is planned for 2025/26.

Rationale for estimating demand and capacity in intermediate care

The overall approach on the allocation was agreed by the Joint Leadership Group, in conjunction with Bedfordshire Care Alliance. Whilst our approach to capacity and demand planning is continuing to

evolve, allocation of funds is targeted at key areas that can have a marked impact on reducing demand and maintaining flow. These approaches are reflected in the schemes in the planning template.

A key aim is to have a dynamic Capacity and Demand tool which is live and actively used by the operational teams. SHREWD - a single, central view of a whole health economy's operational data and ability to add clinical workflow data, including pressure and resources has been implemented. SHREWD Command provides a central view of all operational and clinical data across whole health and social care systems. Quickly allowing decision-makers to view system-wide capacity and pressure. Central Bedfordshire BCF, along with the other three places, contributes towards the cost of the contract for SHREWD as the BLMK system-wide database.

The Phew! App continues to be used to manage patient flow through the community D2A beds, as well as providing a single shared live view of available capacity by location. This tool is invaluable to ensure patients are progressed through the community beds in a timely way, ensuring capacity is maximised and maintaining flow through the hospital.

We have based our expected demand and capacity on recorded activity for our key teams and services, adjusted for seasonal variability based on local activity trackers. Demand has been based on the date of referral to each service, with capacity based on the date of discharge/package start; this approach will continue to evolve over the funding period to ensure that the most appropriate data is used. In order to allow space for normal fluctuations across the period, we have set our base level at the upper end of the range in which where we would expect 65% of monthly activity to fall, based on the standard deviation of the average across the past 2 years; this should provide a good balance between allowing for unexpected increases, while also minimising the likelihood of over-estimation of demand.

The base process remains the same in terms of estimating capacity, but it's worth noting however that demand has been based off of a linear forecast on PHEW data this time round though, rather than the local trackers used in previous years.

This initial capacity and demand assessment is being used to inform how and what services are commissioned over the next few years. We will continue to review and amend these as outcomes and impact on flow are measured to ensure our BCF investments meet the needs of our local population. Our demand and capacity model shows there is potential during periods of high demand for a small, short fall in commissioned intermediate care (PW2) and as a result, we have allocated funds within the discharge funds to maintaining a spot purchase of intermediate care as needed.

Demand for reablement services has increased with direct referrals from both community and acute services and we have increased capacity within the teams to meet this demand. We have been successful in recruiting to the service for both front line support worker roles alongside physiotherapists and occupational therapists. In turn this has supported a sustained increase in better outcomes for people not requiring long-term care and support packages. In addition, we have also restructured the reablement service in a therapy lead context which means that all unregistered workers have timely access to therapies and the associated guidance and oversight in delivering reablement interventions to our residents. The BCF and the discharge capacity fund are being used to meet the increasing demand with additional bed-based and domiciliary care capacity. This investment underpins our overall focus on maintaining flow, delivering timely intervention, supporting people to remain independent in their usual place of residence and proactive care.

Hospital Discharge Fund (HDF)

The HDF has been amalgamated into the BCF creating more flexibility as to how this can be used at place. Due to timescales, the schemes that were funded through the HDG in 2024/25 have been rolled forward and there is no change. However, this will be an area of focus and will be reviewed through the Joint BCF Group for 2025/26 where collaborative plans will support improvement and oversee delivery & performance. There is planned activity in the P2 Intermediate Care project where we are reviewing the commissioning gap in bed provision supporting people with dementia and a proactive in reach pilot project at Bedford Hospital. This is supported by the work PA Consulting did around the BCF review and recommended the need to join up fragmented pathways to reduce delays in discharges, particularly Pathway 2.

How BCF activity will impact headline metrics 1,2 and 3

Metric 1 Emergency Admissions to Hospital (65+)

The 2025/26 plan figures have been calculated based on the current year figures, using the full year outturn, and apportioned across each month based on calendar days. No plan adjustments have been applied to reduce or adjust current year values to a target value.

There are a number of initiatives being implemented including the ambulance services and community services working together to remove people from the stack and treat people at home. Admission avoidance, particularly in relation to preventable ambulatory care conditions, is a key focus of our multidisciplinary working approach. This collaborative programme uses proactive care planning to identify people most at risk of adverse health outcomes. For example, those who have complex emotional and mental health problems; those with long term conditions; the population who are frail and those who are high intensity users (including those on multiple waiting lists) or at end of life.

Expanding our reablement offer to support people being discharged from hospital or to maintain independence at home is a key priority funded via the BCF which is having an impact on our performance against the metrics. The efficiency of our reablement pathways is maximised with the introduction of digital dynamic rostering which provides greater oversight of available capacity alongside a more coordinated approach to delivery of the service.

We have introduced a home recovery (domiciliary) service to complement the wider discharge pathways and strengthen our Home First offer; this is also supporting enhanced navigation of people at the point of discharge to ensure they receive the most appropriate service. This is also being undertaken in parallel with a workstream to integrate and align our pathway 1 recovery and reablement provision with ELFT's equivalent teams and services. It is expected that this will deliver enhanced neighbourhood working teams that are combined with staff from different organisations to provide seamless and joined-up care. The operating model is currently being developed between CBC & ELFT, a key element of this model will be supporting people to leave hospital sooner and/or for people in the community being able to access the appropriate services that will assist them to stay at home as opposed to admission to either hospital or a care home.

We recognise that falls are preventable and there is a strong evidence base and national guidance on effective interventions to reduce the risk of having a fall. Balance impairment and muscle weakness are the most prevalent risk factors for falls and therapeutic exercise is the most effective component of a multifactorial intervention. A new BCF 2025/26 scheme is funding a Falls Prevention Service for Central Bedfordshire and implementation has started. In 2023/24 Central Bedfordshire residents aged 65 yrs and over experienced 3,010 ambulance journeys and 1,566 hospital admissions due to falls, estimated

acute cost of circa £8.4m. In addition, there are primary, community and social care costs due to the need for rehabilitation, re-ablement, packages of care and care home placements. Females account for 60% of this activity, people aged 80 years and over account for 66%. A 5% reduction in falls activity over 12 months would prevent 150 ambulance journeys, 78 hospital admissions 1,017 acute bed days.

This new approach offers an integrated health and social care Falls Prevention Service and involves a team providing dedicated falls service capacity as part of Bedfordshire Community Health Services (CHS) and working in an integrated way with Central Bedfordshire's existing Urgent Home Care Falls Response Service(UFRS) and level one Strength and Balance programme to provide a comprehensive falls prevention offer. The detail of the integrated working between health and social care are being developed and this includes the triage and assessment process, interventions provided and outcomes.

Further to the Pathway 2 Intermediate Care project work, system partners in conjunction with Bedfordshire Care Alliance have been developing a proactive in-reach pilot project. The pilot will consist of a team of partners across community, local authority, community beds and discharge planners to provide onsite real time triage and initial assessment for people who are medically optimised and ready for discharge identified for Pathway 2. The pilot hopes to identify more appropriate pathways, enabling independence and where appropriate, focusing on home first with Pathway 1 and reducing delays in discharge. Impact will be measured through the BCA and project team and the outcome from this work will inform the strategic workstream.

Central Bedfordshire will be measuring the supporting indicators to inform the local position and future planning:

- Unplanned Hospital Admissions Ambulatory Care Sensitive Conditions - Target 2025-2026 awaiting end of year data.
- Emergency Admissions due to Falls (65+).

In the preceding sections, we have described how we are supporting people home from hospital. Early discharge planning is a key feature of our BCF investment, in schemes supporting the integrated discharge hub and our reablement service. Our commitment to improving the transfer of care and flow of patients remains. We have an ICS Delivery and Discharge to Assess Group that has oversight of transfer of care and flow.

The activity relating to the unscheduled care hub, virtual wards and call before you convey contribute towards reducing unnecessary hospital admissions and links to the 'emergency admissions to hospital (65+)' metric under the plan.

Metric 2: Average length of discharge delay for all acute adult patients, derived from a combination of:

- Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
- For those adult patients not discharged on DRD, average number of days from DRD to discharge.

The Discharge Ready Date (DRD) metric measures the time between when a patient is clinically ready for discharge and their actual discharge date. Introduced as part of the Urgent and Emergency Care Recovery Plan in January 2023, the DRD metric aims to improve patient flow and reduce hospital bed occupancy by identifying and addressing delays in the discharge process.

The DRD metric is a key performance indicator in the Better Care Fund planning requirements for 2025/26, aligning with objectives to shift care from hospital settings to home and community-based services. This focus supports individuals in living independently and emphasises preventive care over reactive treatment.

By closely monitoring the interval between a patient's discharge-ready date and their actual discharge, system partners can identify systemic bottlenecks, implement targeted interventions, and ultimately improve people's outcomes while optimising resources.

Please note, the BLMK wide response post discussion with the East of England Team and escalation to the National Team.

Bedfordshire Hospitals Foundation Trusts (BHFT) have provided a thorough analysis of all the local and national inconsistencies in the reporting of Discharge Ready Date (DRD) data. The numbers reported via SUS are a lot lower than those reported to Healthcare Operations Data Flows (HODF) and SitRep, as Secondary User Services (SUS) validates out "NULLs". In addition, this is reflected as accuracies in line 34 of template. HODF reports performance of discharge date matching DRD at 90.1% compared to SUS being approximately 31%, this is because HODF includes all NULLs but assumes the actual discharge date matches the DRD; SUS excludes these. Nerve Centre (the BHFT Electronic Patient Record (EPR) from which this data is extracted) has been set up to support clinicians and operational teams inputting planned "discharge ready date" in order to facilitate good clinical practice. Unfortunately, the semantic similarities have caused some ambiguity when it comes to reporting. There have been a number of complexities in the setting of the discharge delay metric plan, which have made the decisions challenging - plans may need revisiting as we travel through the transformation plan.

To provide assurance and address the data quality issues, the Trust's Transformation Programme will align system capabilities, staff knowledge and functional requirements for DRD. To deliver the change and the plans including the 1% monthly improvement will be clearly owned and a joint responsibility between the Trust, the ICB and other system partners.

Based on January's 2025 discharge volumes, BHFT estimate to be discharging 58% of patients on their discharge ready date currently. It is provisionally jointly proposed a 1%-point improvement each month for the next 12 months to get performance to 70% by the end of March 2026. Reported performance against this target will be reviewed monthly at least, in line with the Transformation Plans. As this is a wider than BCF reporting issue, a report will be sent to the East of England BCF Leads to outline the plan in more detail and ensure connectivity between NHSE E of E Team and the BHFT and ICB Leads for the DRD plans. Current expectations are that the impact of this plan will be recognised in the numbers by the end of June 2025.

At this time, we have forecast that our available 2025/26 capacity to deliver UCR activity will remain flat and the same as 2024/25. This is due to the RR UCR team also being deployed to support increasing numbers of Stack and Virtual ward activity. As per 2024/25, we will look to flex capacity from other service areas within the months where demand is projected to be higher than capacity but based upon increased demand across all service areas this may prove more challenging this coming year. We will look to increase capacity where required through bank and agency staff during peak period but again, this will be subject to financial constraints and will be harder to implement this coming year.

The data will be reviewed regularly and any improvements in the position will be provided to the BCF Team through a narrative progress update in the 2025-2026 Quarterly Reporting Templates. Until the DRD data set provides a more accurate position on discharge delays, Central Bedfordshire will not be

measuring the supporting indicators for DRD until we are confident in the DRD data. If this decision changes as we progress through the year, we will update the BCF Team in the Quarterly Reporting Template.

Metric 3: Admissions to Long Term Residential Care Homes and Nursing Homes (65+ per 100,000)

In setting the target for 2025/26, a range of transformation projects taking place during 2025/26 have been taken into consideration. The expenditure in the BCF is to support Step Up/Step Down provision, Reablement, Equipment, Carers, the hospital Discharge team as well as investing in more independent living, via the capital allocation, are all examples of helping to prevent, delay or reduce the need for care home admissions. This is all against the backdrop of an increasing older population in Central Bedfordshire. It is anticipated the projects will have some in-year effect but will reduce our admissions more significantly from 2026/27 onwards with the integration project planned between ELFT and CBC. The rationale as to why this is challenging is very clear direction of travel, as below.

As of 4th April 2025, Central Bedfordshire had 372 placements for 2024/25 and when all admin/data entry is completed we expect this to be circa 380. Given the clear trend since 22/23, we believe 380 is challenging.

Year	**Placements**
2022/23	304
2023/24	332
2024/25	372

We have maintained our investment in the Adult Social Care Market although the financial pressures facing Adult Social Care meant that for the year 2024/25, we were unable to offer blanket uplifts to all providers and instead took a different approach depending on the type of provision and we will also need to carefully consider our approach for 2025/26 as budget pressures remain.

Our focus on supporting the workforce, the fee uplift for providers, an expanded recovery and reablement offer, with bed-based capacity, further investment in the voluntary and community sector as set out in our schemes, are key elements of our demand and capacity planning to ensure the system is well placed to meet the challenges for winter and the increasing complexity of need.

We encourage a proportionate approach to dependence on institutionalised forms of care. Our focus on Discharge to Assess and Home First with our BCF investment is ensuring that more people are able to return to their usual place of residence.

Other BCF funded services, that support people to return to their own homes, include investment in technology enabled care and telecare which complement reablement and domiciliary care.

These initiatives are supported through additional social work capacity and voluntary sector funding through the BCF. Crisis prevention plans with carers are also being put in place. In addition, Central Bedfordshire Council's investment programme 'Meeting the Accommodation Needs of Older People'

(MANOP) is increasing access to more independent living (extra care) accommodation which will help mitigate admissions into residential care.

High Impact Change Model

We have undertaken a self-assessment of the High Impact Change Model (HICM) in our area, and action plans have been drawn up and are being delivered in conjunction with our winter plan.

We have also completed capacity and demand management for beds within BLMK, as well as undertaking the 100-day challenge. Action plans have been developed in response to this, particularly to support the winter period.

A Transfer of Care Discharge Hub with improved assessment and planning processes is in place. Central to these are actions to decrease the length of stay, through Discharge to Assess and increase the use of community beds and home-based intermediate care services.

We have contingencies in place for acute and community multi-disciplinary teams and are expanding our multi-disciplinary approach process. The main focus remains on discharge to assess and home first model, as these are key to our approach.

We have introduced a home recovery (domiciliary) service to complement the wider discharge pathways and strengthen our HomeFirst offer, this is also supporting enhanced navigation of people at the point of discharge to ensure they receive the most appropriate service.

We are maximising the efficiency of our reablement pathways by means of the webroster system across the Reablement service, this has enabled us to have greater oversight of our available capacity and respond to varying levels of demand with greater ease. It is also planned that this system will be pivotal in integrating our pathway 1 provision of services delivered by the council and ELFT.

Care Act Duties - Supporting Unpaid Carers

Central Bedfordshire launched a 5-year Adult Carers strategy in 2022, and the BCF supports the delivery of this overarching approach and aligns with the key themes within the strategy.
The key themes within the Carers Strategy for Central Bedfordshire are:

- Identifying, Recognising and Involving Carers: Working with partners across health, social care and the wider system to ensure that carers are identified earlier and provided with support. We will include carers in designing, commissioning, and evaluating the services they use.
- A Life Alongside Caring: We will support carers to take breaks from their caring roles, to enable them to work and to have interests outside of their caring role, ensuring that they are aware of opportunities to participate and support them to do so.
- Supporting and improving the health and wellbeing of carers: We will ensure that appropriate health and wellbeing services are available for carers living or caring in Central Bedfordshire including commissioned services.

- Supporting carers to learn more about their caring role and what is important to them: We will support carers to access the information and training they need to continue their caring role safely and appropriately.
- We will support carers to adjust to a life after their caring role ends. This will include practical advice and support as well as emotional support. We will ensure that former carers are aware of opportunities for them to participate in their communities or interests.

As a result of the Adult Carers Strategy, a delivery programme has been set up with a Board overseeing progress. To date, this has included activity such as reviewing information and advice, working with our provider to offer different types of support such as on employment, wellbeing, and mental health. We are progressing a review of carers breaks and respite and are reviewing our approach to regular carers workshops and engagement to increase participation.

The BCF plan is funding a Carers Support Service provided by Carers in Bedfordshire to identify and support carers, while providing a communication pathway into decision making. This will continue to be delivered in partnership with third sector partners to maximise the potential for community outreach.

The BCF plan also funds an online digital support service for carers through Mobilise. This service complements that provided above by Carers in Bedfordshire, providing access to appropriate information and advice outside of working hours. Pilot projects of this service had a great impact on working carers and has seen an increase in male carers accessing information, advice and peer support. We are intending to recommission these services over the coming year to ensure they continue to meet local need and provide value for money.

Disabled Facilities Grant (DFG) and wider services

Central Bedfordshire is a unitary council and has responsibility for the disbursement of DFGs. The Council is well placed to facilitate the use of the disabled facilities grant and works collaboratively to help maintain independence. This includes enabling people to remain in their own homes, facilitating discharge from hospital with person-centred support, improving experience of care through equipment and digitisation as well as enabling care to be delivered closer to home.

Year on year since 2020/21 there has been a significant increase in the number of DFG referrals received by Housing Services. This is due to the increasing elderly population within Central Bedfordshire. In addition to the increase in numbers of referrals the nature of works has become increasingly more complex to meet the clinical needs of residents, and the costs of materials and labor has increased significantly, putting a pressure both on budgets and staff delivering the grant capital programmes. We remain focused, however on ensuring that the DFG funding is used flexibly to meet the needs of vulnerable people and improve health and social care outcomes.

DFGs will continue to be used, alongside the Council's Housing Assistance Policy, to secure early discharge from hospitals and reduce non-elective admissions. The focus of the DFG capital grant continues to be on expanding the use of assistive technology to promote independence, self-management, reduce reliance on institutional forms of care and facilitate early discharge from hospital.

Some adaptations for Central Bedfordshire residents are completed through the Prevention Assistance Grant (PAG) based on providing adaptations without delay. The criteria for the PAG are currently £4000 limit with the needs of the person to assist hospital and care home discharge or prevention of hospital / care home admission. The PAG is not means tested and does not automatically need assessment from Occupational Therapy. Other social care and health professionals can refer to Private Sector Housing for this grant.

We are continuing our digitisation programme as part of the national digitising social care programme. We are working with our domiciliary care providers to promote digitisation tools and assistive technology to promote a consistent, joined up service and more integrated approach for improving the transitions between care.

We will also explore introducing specialist equipment to support independence within Care Homes to provide a better experience for residents, particularly those who are temporary residents as part of the step up/step down schemes to help them stay independent and at home for longer. As part of our programme of enhancing health in care homes, we are investing in aids and equipment to deliver better care and prevent hospital admissions, including investment in lifting equipment, reducing the need for an ambulance call out and subsequent conveyance where avoidable in the event of a fall. The programme of digitisation and use of remote baseline monitoring in Care Homes will enhance access to clinical advice and support as part of the new GP Network Contract and NHS Long Term Plan.

We will continue to focus on initiatives that help to prevent the need for admission to hospital and enable joined up and multidisciplinary working with access to care locally.

Equality and Health Inequalities

Inequalities are an explicit priority of the BLMK ICS, and a cross-system inequalities group has been established, and we are collaborating on multiple ICS work programmes including population health management, health inequalities and mental health, as well as working to tackle inequalities in access to services in areas of deprivation.

Our Place-based Plan seeks to ensure that everyone can access the services they need, while working to address wider determinants of health to give everyone the best possible outcomes. It sets how health inequalities will be reduced, particularly for vulnerable people, those with frailty and complex needs who often do not have equity of access to health and social care.

Through anticipatory care planning, we want to achieve a reduction in unplanned primary, secondary and crisis social care with a continuing focus on improving outcomes in population health and healthcare. Co-production with our residents ensures people's needs are at the heart of what we do and takes account of inequalities. For example, engaging with people to understand the impact of Covid and co-producing impactful actions to reduce inequalities.

Our BCF Schemes continue to work to reduce health inequalities and disparities and seek to give equal prominence to mental and physical health. They also seek to protect the most vulnerable by bringing together partners and communities to address the wider determinants and socio-economic drivers that underpin poor health outcomes, such as poor housing, poverty, economic insecurity and low skills. A

key scheme supports our comparatively large Gypsy and Traveler communities, ensuring they have timely access to care and facilities to live a healthy life and remain independent within those communities.

For example, the BLMK ICS Data Strategy outlines a roadmap that will unlock proactive identification and support of individuals who are most likely to need health and care interventions, via more comprehensive datasets, advanced data analytics and reporting, risk stratification tools and PHM capabilities across the ICS. The strategy enables health and care partners to better tailor interventions to individuals, taking account of wider factors such as social determinants of health, and ensuring that interventions are in place to address health inequalities throughout BLMK. In addition, the population health management approach has adopted core20 plus to ensure delivery of services that are proportionate to the degree of need and is using population health information to identify groups experiencing poor outcomes. This information has been shared with our Primary Care Networks, who have now included these within their priority areas for action. Key areas of focus include chronic respiratory conditions, hypertension and other chronic ambulatory care sensitive conditions (CACSCs).

A key priority for Bedfordshire Care Alliance is to address unwarranted variations in quality, access and outcomes for people, and by using joined-up data and digital capabilities to understand local priorities, we will be able to track delivery of plans, monitor and address unwarranted variation in outcomes, health inequalities and drive continuous improvement in performance and outcomes.

Conclusion

The Central Bedfordshire Integration and Better Care Fund (BCF) Plan for 2025/26 outlines a comprehensive and collaborative approach to delivering integrated, person-centered health and social care services. With an ageing population and increasing healthcare demands, this plan priorities prevention, independent living, and community-based care to reduce reliance on hospital services.

Through strategic investments in digital health solutions, workforce development, and enhanced partnerships, the plan aims to improve health outcomes, support timely hospital discharge, and provide proactive care. Key initiatives such as the Virtual Ward, Falls Prevention Service, and Integrated Neighbourhood Working model will ensure better access to care closer to home.

Governance oversight through collaboration with the Integrated Care Board, Health and Wellbeing Board, and local authority ensures accountability and effectiveness. The plan aligns with national priorities and local strategies to create a sustainable and resilient health and social care system for Central Bedfordshire.

By fostering innovation, strengthening community support, and enhancing service integration, the BCF Plan for 2025/26 sets a clear direction for achieving better health and wellbeing outcomes for all residents. The commitment to collaboration and continuous improvement will be key in delivering a more responsive, effective, and sustainable care system.

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